contact

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Leadership and Community Participation for Health

Part II

INTRODUCTION

Much has been written and said on primary health care (PHC) since the historic conference at Alma-Ata in 1978, yet much of what one finds in these statements betrays confusion in the understanding of the basic principles and strategies of PHC. What is described by many authors and practitioners as PHC very often lacks PHC's key elements. Those who are uncomfortable with these omissions have suggested various modifications to the name to bring the focus of PHC back to its most central and radical element: community participation. The most common of such alternative terms is community-based health care (CBHC).

The CBHC approach is often presented as an alternative to PHC, when in fact it is PHC as it was originally intended. Central to CBHC, or true PHC, is empowerment—the enabling of all people to be actively involved in the essential aspects of their lives. Empowerment is the process by which people, especially the disadvantaged, work together to increase their control over the events that determine their lives. It is a personal and group process combined. It cannot be done for people; they must do it for themselves.

The CBHC programme addresses health issues on the basis of a broader understanding of health and how it can be cared for. Seen in the context of human dignity, development, and total well-being, health action becomes an entry point for social action and wholistic development. The community-based programme focuses deliberately on the disadvantaged. It recognizes that people are already engaged in caring for their own health, confronting daily challenges with what they know and have. In CBHC, the root cause of ill health is seen as mainly social, economic, and political injustice. Therefore the CBHC approach aims at dealing with the oppressive system. The community contributes not only resources and labour to these efforts, but also ideas, and the community members share in power and decision-making.

In CBHC, the role of the health worker is to facilitate the empowerment process by creating an environment in which people empower themselves. The role of the CBHC facilitator is in direct contrast to the common view of the health professional as an "expert," doing things for helpless others. Health professionals are generally trained to see themselves as experts and health problems as strictly medical. Thus they design medical solutions to problems that are more than medical and hence unlikely to respond adequately to purely medical prescriptions, however appropriate. If and when health professionals evaluate their interventions, they are often surprised at how little has been achieved.

In this issue of *Contact,* the second in a two-part special series, we present two programmes from India, both with long experience in community participation for health development: the Comprehensive Rural Health Project in Jamkhed, Maharashtra, and the Deenabandu Training Centre in community-based actions for health in Deenabandu, Tamil Nadu. We also include an article from the Asian Health Institute, Aichi, Japan—a long-time partner of CMC—on their specific participatory training methodology. The second half of our interview with David Werner is continued from *Contact* No. 127, this time focusing on PHC and community participation. These articles and interviews, undertaken specially for *Contact,* are intended to explore the evolution of PHC and the on-going search for the most effective strategies for community participation and, ultimately, community empowerment.

COVER

Illustration and design by Edwin Hassink, WCC.

THE COMPREHENSIVE RURAL HEALTH PROJECT, JAMKHED, INDIA—

THE EVOLUTION OF A HOSPITAL-BASED PHC PROGRAMME AS A FORCE FOR SOCIAL TRANSFORMATION

In August 1972, *Contact* published a paper, presented at a Christian Medical Commission meeting by Dr Rajanikant Arole, on a rural health care project that he and his wife, Dr Mabelle Arole, had started two years earlier in the village of Jamkhed, Ahmednagar District, Maharashtra State, India. The paper explained how they arrived at the idea of the Comprehensive Rural Health Project (CRHP) after having discovered the limitations of a purely "curative, prescriptive, and clinical" medical practice:

> My wife and I were both concerned about the medical care of the rural population of India, and so after graduation we both went to a hospital situation in a rural area and worked there for about five years. To our amazement, at the end of the five years, we found that all we had done was to take care of patients who came to the doorsteps of the hospital, but we had done little for the general health of the community around us.... This made us realize our need for public health training to enable us to reach out to the community.

So the Aroles had returned to school, this time to study public health. The design and strategy of CRHP originated as part of M. Arole's post-doctoral research. Although originally intended for another site in Maharashtra State, CRHP was finally located in Jamkhed because of the promise of cooperation extended by the local people, but also because the site offered an ideal testing ground for the CRHP strategy. In his earlier *Contact* article, R. Arole explained the choice of location:

> While we were studying in the United States, we decided that we would go to an area where there was no Christian witness because we wanted to establish a Christian witness in an entirely non-Christian area. Secondly, we wanted an area where there was an acute need for medical care and where there was no possibility of future development, either in the health field or in other fields, so that after five years there would be no other factors to account for the changes that take place.

Jamkhed, which had been officially classified as "backward," fulfilled the criteria. It also happened to be where R. Arole had been born and raised. The local economy in the Jamkhed area is based on agriculture. There is no industry. Women make up approximately 70% of the labour force and work for daily wages. In most villages, a few families possess most of the land, and approximately 60% of the people are poor, landless farmers. Drought is a chronic problem. As in other rural areas in India, the caste system in Jamkhed and its surrounding villages is strong. About 20% of the population is made up of "untouchables," or Dalits (see box on pages 6 and 7).

The goal of CRHP was to develop a programme suited to the needs of the local community, but also compatible with the resources available to the community. The method for achieving this goal was mapped out.

A main centre would be established at Jamkhed, offering diagnostic help, facilities for emergency surgery, and emergency medical care. There would also be a number of subcentres in surrounding villages. Auxiliary workers and paramedical workers would supplement the expertise provided by the health professionals.

The cooperation and involvement of the indigenous practitioners, health officials, school teachers, and *dais* (indigenous midwives) would be needed, and there would be cooperation with other government programmes. Finally, at the end of six years, CRHP would have to be self-supporting.

The programme objectives were:

- to reduce the birthrate from 40 to 30 per 1000 population;
- to reduce the mortality rate in children under-five by 50%;
- to identify and bring under regular treatment leprosy and tuberculosis patients;
- to train indigenous workers and offer field training to health workers.

CRHP's main activities to accomplish these objectives would be the establishment of an under-fives' clinic, family welfare programmes, family planning programmes, leprosy and tuberculosis programmes, mobile clinics, and a school health programme. Curative services for acute surgical and medical emergencies and diagnosis would also be carried out at the project centre in Jamkhed.

In a recent interview with *Contact,* the Aroles looked back on the early years of the programme and its guiding philosophy (see box).

CRHP as it has evolved

The original goal and objectives of CRHP, as well as the programme's main activities, resemble those of other hospital-based rural health care programmes undertaken in the last two decades. Unlike many such programmes, however, CRHP has steadily succeeded in achieving and then exceeding its objectives, as the available statistics show.

In 1971, the programme began by serving seven villages. By 1992, that number had grown to 200. Also by 1992, the population served had increased from the original 10,000 in 1971 to over 250,000. By 1987, the birth rate had dropped to 24 per 1000 population. Original research by the Aroles before the start of the programme in 1971 had shown family planning to be adopted by less than 1% of eligible couples in the Jamkhed area. By 1981 family

continued on page 5

In February 1992, Contact *interviewed the Drs Arole at Jamkhed on their work and their approach as these have evolved since the beginning of the Comprehensive Rural Health Project in the early 1970s. Below are excerpts from that interview, focusing on the early years of the project and on the Arole's approach to PHC and community participation.*

R. Arole: When we first started, we spent nearly six to eight months just meeting with people and making contacts, even before we started the medical work. Genuine community participation happens when the community is informed, when the community is very clear about what is needed to improve their health. To ensure this kind of community participation, one has to spend enough time with the community. That is number one.

The second thing was really sensitizing people to the non-medical interventions that have a direct effect on health, such as agriculture and water development. When you spend time with the people, you realize that they are much more concerned about food and water than health. At the same time, of course, they realize unconsciously that food and water have a bearing on health.

Most so-called educated medical people go in for curative services, and this is what people expect of doctors. Instead, we took the initiative in improving the people's agriculture and water supply, which are very close to their hearts. What they want is to ensure their livelihood. Commu-

nity participation can only be ensured when people are organized around something that is vital to them.

Contact: Right now you are talking about the farmers' groups that you organized in the villages.

R. and M. Arole: The farmers' groups and the women's groups.

M. Arole: The women have also been organized around income generation, and, as a result, the women also have a lot of income now.

Contact: But in the beginning it was curative services that brought the people to you?

R. Arole: Yes, it was just a way to get acquainted with them. The question to ask is, How do the village people perceive your role? They don't see a doctor as someone becoming involved in their water and food supply and all that. The village has a slot for everybody, and we had to ask what kind of slot they had for us. They saw us giving medicine for fever and putting on a plaster. We also had to perform that role in order to get their acceptance, in order to establish credibility.

But when we had fulfilled our role, then there was time to deal with them as friends. So we said, "Look, we are good doctors. We perform operations, but we can also teach you how to have good health. We can also teach you how to prevent illness. So which is better? Do you want to have the illness, to then spend money and get cured, or do you want to learn to live healthily. For you to have good health, you need food and water." Our health education was like that. That is how we did it.

We could never have organized people around health. We could not ask people to come and say, "Let's have a talk on how to clean your teeth." Nobody is going to come. But if I say, "Look, 30% or 40% of your children are malnourished. Let me teach you how to boost your agriculture." The more you talk about agriculture and water, the more people talk to you.

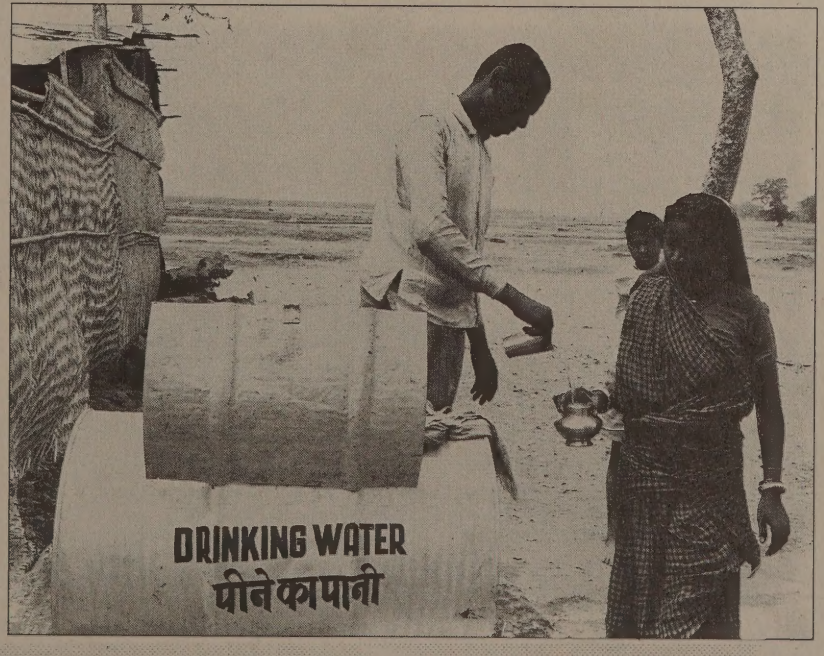

Photo: WHO

Community participation can only be ensured when people are organized around something that is vital to them, the Aroles discovered. "When you spend time with the people, you realize that they are much more concerned about food and water than health, though, of course, they realize unconsciously that food and water have a bearing on health."

So these are the two things. Radically speaking, the real cause of ill health is poverty and lack of resources to support their livelihood.

Contact: What is your philosophy, then, behind the hospital, behind these curative services?

R. Arole: PHC without referral is doomed to failure. But PHC is first, and the hospital is next. It cannot be the other way around. You cannot establish a hospital somewhere without any idea of what you are doing there. You cannot just establish the hospital and then carry out some surgery or a few investigations without having any understanding of the needs of the people.

Many mission hospitals have been established as a kind of a shop, offering a variety of commodities. And the commodities in the shop depend on the arbitrary thinking of the doctor. Suppose the mission hospital has a missionary who is a plastic surgeon or other specialist. Depending upon the expertise of that doctor, the mission hospital establishes a service, which may have no relation to the actual needs of the community. Instead you must start with the people.

We started with the people. We did the surveys. We found malnutrition in under-fives and pregnant mothers and a need for family planning. We found certain chronic illnesses, tuberculosis, leprosy, and blindness, for example. These were the problems. Now, how do you establish a secondary care for people with these problems?

Take the pregnant mother. What are the problems she is likely to have. She may bleed, so she may need blood transfusion, which requires crossmatching and equipment and someone to give her blood. She may need caesarean section, so you have a simple operating theatre and someone to give anaesthesia. You are talking about tuberculosis, so you must have a laboratory where you will do the sputum examinations.

M. Arole: It is the services at the first referral level that are important. Take the caesarean section, for example. If there is no facility for doing a caesarean section, any amount of ante-natal care provided as part of a PHC programme will not succeed. If one woman in the group needs a caesarean and you don't have the means to do it, then the whole ante-natal care programme is dead.

R. Arole: Primary health care will be successful if you have a proper referral service up to the second level. That is the key. The number of patients who are actually referred is very small.

Bearing in mind the aim of PHC and the likely need for services on the secondary level, a hospital, like this one, can be established to fulfill the needs of the PHC programme. □

Illustration: Women in Action

Though established with the best of intentions, mission hospitals often offer services that have no relation to the actual needs of the community. "Instead you must start with the people," insist the Aroles.

planning had been adopted by 55% of eligible couples. Infant mortality had been more than halved, dropping from 80 to 25 per 1000 live births by 1992. Malnutrition, which in 1971 had been as high as 30%, by 1987 had fallen to 4%. Immunization coverage, which had been .5% in 1971, had peaked at 97% in 1984 and then levelled out at 80% in 1991.

The school health programme that had been one of CRHP's original activities was dropped. It had proven unproductive for the amount of effort involved. "Secondly," explained R. Arole, "it was only the children of the privileged who were going to school in the first place, and we are working for the poorest among the population, so out it went. Instead we have developed a programme based on Child-to-Child materials. The village health workers now teach the children how to read and write, how to take care of their younger siblings if they get diarrhoea, and how to take care of their animals. The children also learn cooking and sewing."

The feeding programme, which had also been among the programme's original activities, was continued for about six years—during a time when malnutrition as the result of a severe drought in 1972 was endemic. After enough food began to be produced in the villages to meet basic nutritional needs and enough health education was being given, the feeding programme was stopped.

Significantly, the CRHP had become self-supporting, as originally intended.

Even more significantly, while meeting and expanding its health-related objectives, the programme has profoundly affected the underlying social structure of the villages it serves.

Enter the village health worker

Initially, the programme had counted on nurses to liaise between villagers and the CRHP services and also to act as catalysts for social change. The Aroles were soon disappointed in this expectation. The nurses were not happy living alone in remote villages, and there remained a barrier between the nurses and the villagers as the result of their differing levels of education. The Aroles are frank about the effect that this situation had on their thinking and how it led to a breakthrough that would change the character of CRHP.

> We had gone to Johns Hopkins [for our degrees in Public Health], where we had talked about community participation and all that, yet it was quite ingrained in us that we, as doctors, were going to do everything. So this idea of delegating our work to the nurses was not open to us. Our idea of delegating was that we would do the diagnosing and they would do some follow-up. When we came here our idea was "We'll see every patient and tell the nurses what to do."
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> But after being here and seeing how overwhelming the work was, we felt that the nurses should stay in the villages. And at that time, their skills were limited, so that had to change and we had to give them more responsibility. Then we found that the nurses were not bringing any change to the people. So the first change in our lives came when the villagers suggested that we train the village women to be village health workers. At that time we believed that only the doctors should be treating illnesses and that these women should be involved in nutrition education, but not in health education.
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> Then slowly the villagers began to trust their ability, and then they asked us if we could teach them to deliver babies. We taught them and they became very good at it. And then we taught them about family planning. So whatever we taught them they became very good at. And actually that was where our whole idea about the capability of illiterate village people began to change.
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> At the same time, we were deeply disappointed with the so-called educated people [among our staff]—their bickering and their selfishness and the way they were trying to shirk responsibility. So this conflict arose: disappointment with the so-called educated fellows and appreciation for the poor and illiterate. And this feeling grew. Over time we have become quite disdainful of the people who call themselves experts. This is where we are now.
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> And also we have realized how non-medical interventions affect the health of the people.

continued on page 8

INDIA'S DALITS

The World Council of Churches (WCC) first took up the concerns of Dalits in India in 1983. Since then, the WCC has become increasingly involved in the struggle of the Dalit community against oppression. Recently, One World, *the monthly magazine of the WCC, published a background article on the situation of the Dalits (No. 175, May 1992). We reproduce below excerpts from that article, by Miriam Reidy, with permission.*

In Sanskrit, *dal* means to crack, split open, or break. Used as an adjective it means broken, torn asunder, or trampled. The name *Dalit* began to be used in the 1970s by a section of India's population known officially as Scheduled Castes and Scheduled Tribes, or *harijans* (Gandhi's term, meaning Children of God). It evokes the bondage and agony, anguish and aspirations of a people victimized, exploited, and oppressed throughout 3000 years of Indian history.

Dalits constitute between 15-20% of the Indian population of over 800 million. Born outside the Hindu caste system, they are assigned the very bottom rung of the social ladder. In the not-so-distant past, Dalits were expected to shout or ring a bell when a non-Dalit approached. Branches were tied to their waists to sweep away their footprints. Earthen pots tied around their necks served as spittoons. Their ears and throats were to be plugged with molten lead if they tried to hear or recite the scriptures.

Today, Dalits are rejected by caste Hindus in all areas of life as in death. In rural areas, where the majority live, they are segregated from the main village and barred from using common village wells and temples. Condemned to perform such "unclean" occupations as leather working, digging burial pits, and carting night-soil, Dalits constitute India's largest group of landless, low-paid or bonded agricultural labourers. They suffer disproportionately from illiteracy and under- and unemployment. They are the poorest of the poor.

A history of oppression

Why and how has a particular group been singled out for unmitigated oppression over more than three millennia? Archaeological evidence suggests that around 1500 BC the subcontinent was invaded by a series of Aryan tribes who subjugated the native inhabitants, appropriating their land and material resources. Some 200 years later, a collection of hymns relating the sayings and doings of the gods, the *Rig Veda,* laid the foundations of Brahmanical culture and religion.

According to the Rig Veda, people were divided into four *varnas:* the Brahmins for praying, the Kshatriyas for fighting, the Vaisyas for producing goods, and the Sudras for manual tasks. Non-Aryans subjugated during the Rig Veda period were integrated into the lowest caste. By the time the remaining non-Aryans surrendered, they were no longer identified with any existing *varna* and were thus considered outcastes.

Slowly, this primary differentiation developed into a full-fledged system of segregation and untouchability. Based on religious myths of purity and pollution related to people, places, and things, the system was codified around 500-300 BC. Brahmins, at the top of the social hierarchy, followed "pure" professions, ate "pure" vegetarian food, and worshipped "pure" gods. Outcastes exercised "impure" professions, ate "impure" food, and worshipped "impure" gods. Hence they were untouchable. This extreme form of social stratification conditioned Dalits to accept

their misery as punishment for sins supposedly committed in previous lives.

Efforts in this century to improve the Dalits' condition have largely failed. Gandhi inspired a major effort to integrate Dalits into the Hindu community by inculcating in them upper-caste "Sanskritic" values, such as abstention from alcohol and meat, cleanliness, self-discipline, and education. Along with this approach went a range of economic measures, including land grants and positive discriminatory policies in education, employment, and political representation.

The failure of these measures can be explained in part by the opposition they aroused. Caste groups see their own access to jobs, education, and power being undercut by "privileges" accorded to Dalits. The failure of Gandhi's "Sanskritization" can also be explained by what happens when the values of a "higher" foreign civilization are extolled to a people whose own culture and traditions have been despised to the point of being wiped out. Apathy and fatalism among the oppressed are some of the resulting negative psychological effects. According to a 1980 report of the Backward Classes Commission, "The real triumph of the caste system lies not in upholding the supremacy of the Brahmins, but in conditioning the consciousness of the lower castes to accept their inferior status in the ritual hierarchy as part of the natural order of things."

Hope of escape unfulfilled

At several moments in their history, the Dalits opted out of the system that was oppressing them. Sweeping across India in around 400 BC, Buddhism challenged Brahmin supremacy and attracted large numbers of outcastes. During the Middle Ages, Dalits joined several other anti-caste groups. During the Mogul period, others converted to Islam, and others again to Sikhism. During the second half of the 19th and first half of the 20th centuries, many Dalits converted to Christianity, encouraged by a vision of Christ's kingdom and hope for freedom.

Today there are some 30 million Christians in India, of whom Christians of Dalit origin form the majority—between 50-80%. With only a tiny minority of upper-caste people, the church in India is really, in terms of numbers, a Dalit church. Yet caste discrimination is present in the churches. Some have separate pews and graveyards for Dalit Christians; in others Dalits may not take the sacrament before it is offered to upper-caste Christians. Christians of different caste and sub-caste origins neither eat together nor intermarry; in some cases, Dalit Christians are confined to their own congregations.

Christian Dalits are actually "twice-alienated." Non-Dalits still treat them as untouchable. They suffer from the same economic, social, and educational disparities as other Dalits, with the added disadvantage that, because of their religion, they may not receive the government benefits extended to Hindu Dalits.

Resistance

Disappointed by government policies designed to uproot the caste system and frustrated in their attempts to escape oppression by conversion to other religions, Dalits today are drawing strength from the daring assertion that they are indigenous people—daring because all traces of Dalit history, language, and culture were wiped out as part of a deliberate strategy of domination. History is written by the dominant classes; the Dalits "lost" the memory that once the land was theirs. That they are regaining it is a sign of renewed resistance. They are discovering that unless "Dalitness" becomes the dominant note of their identity, no movement or ideology can liberate them. Their role as Dalits is not simply to suffer their lot, but to take responsibility for their destiny. □

> Taking into consideration social issues like the status of women and the caste system was very new to us at first, but then we realized how they have such a major role, especially the status of women, in changing the health of the people. That was new to us.

The Aroles describe their model for PHC as consisting of a "three-tier system of delivery of health care. Each village has a village health worker who provides primary health care. The second tier is the health team, which visits her every one or two weeks to help her with activities. The third tier is the physician with specialized services and onward referral system. The village health worker plays the most vital role in this system....The village health worker is available at all times. She is there to give medicines and conduct deliveries, and, above all, she is there to support the people emotionally and psychologically. Since she is from the village, the people find it easier to accept and trust her than the young Auxiliary Nurse Midwife, who is not one of their own....The role of the village health worker is as an agent for change."

By necessity, the Aroles changed their thinking and modified their approach, and the result has been a catalyst for social change. The lives of individuals and whole communities have since been affected. Before she became a village health worker, Salubai of the village of Rajuri, for example, was an outcaste. Through a translator, she told her story to *The Lutheran Standard* (May 4, 1984), a publication of the Evangelical Lutheran Church of America:

> Salubai was married when she was 10 years old and became pregnant when she was 14. The childbirth was difficult and the child was born dead. "I was thrown out by my husband. So my position was the lowest in society. I am a harijan." When she was selected by the Aroles for training as a village health worker, the villagers of Rajuri were skeptical at first. "I was not allowed into their homes." She encountered more resistance when she moved her nutrition programme into the harijan section of the village. Children from caste homes "would come, against the wishes of their parents," Salubai relates. Parents would tell their children, "You must not eat from the hand of the harijan woman." The mothers were "annoyed when their children would do this, but they accepted it." Often, when Salubai entered a caste home, she found that all valuables had been put away, and she was told not to touch anything. Once, after helping deliver a baby in the home of an upper-caste family, she was offered tea in a "special, cracked cup so I wouldn't pollute the good cups." The new mother protested to her parents: "You didn't think I would be polluted [during the delivery], so why are you making such a fuss?" Salubai declined the cup, saying, "I don't drink tea." Change came slowly.

In a visit to Jamkhed in February 1992, *Contact* spoke with members of the *Mahila Mandal,* or women's club, of the village of Rajuri. Salubai was there and spoke of her work and the changes that had taken place as the result of the creation of the women's club. Asked about the caste system, one of the women replied that the caste system had been very strong in their village, but this was no longer the case. The women all sitting together proved it.

The Aroles may not have anticipated the degree to which village health workers would become key to CRHP, yet effecting social change had always been one of the underlying motivations behind the programme. In their

Photo: C. Jagel

Village health worker Salubai and members of her village women's group discussing changes in their village with a group of visiting health professionals.

interview with *Contact,* in the context of the evolution of CRHP, they spoke of the process of social transformation (see box below).

The future of CRHP

Recognition of the achievements of CRHP, as a successful primary health care programme but also as a force for social change, is now widespread in India and internationally. The Aroles have been called upon to extend their work and to cooperate increasingly with government in the provision of health services in the Jamkhed area and beyond. The Government of Maharashtra, for example, has asked CRHP to train all of the 3000 "village health guides" for the Ahmednagar District. Some of CRHP's earliest village health workers play a leading role in this training. The CRHP has also been requested to provide training at the higher levels of the government health service.

During the past several years, Jamkhed has been visited by health professionals from over 85 different countries, who wish to study firsthand the CRHP experience. The Aroles now wish to formalize the training that they have been providing on an ad hoc basis to such visitors. They have recently developed a model for an International Training and Research Centre in Primary Health Care at Jamkhed. The centre will provide six weeks of training in PHC to doctors, nurses, administrators, policy makers, and others involved in health and development.

Asked if this could be considered an inevitable development for a mature primary health care programme, R. Arole replied, "Yes. We decided that instead of expanding all over we would establish this international training centre for PHC. Most PHC training is theoretical. Here we can give hands-on, practical training with the involvement of the community." M. Arole was quick to add, "But what is really unique is that CRHP village health workers have gone out to regional training centres in Maharashtra, and *they* have been the ones who have been training the doctors on how they should go about community-based health care. *They* explain the problems in the villages and what the training should be. The whole thing is done by village health workers."

The success of CRHP is often attributed to the charisma of the Aroles. Partly to disprove this, they have absented themselves from Jamkhed for the last two years. During this time, they developed the International Training and Research Centre model and taught public health—"bolstering PHC at a time when governments are not in support, keeping PHC alive."

continued on page 13

Our interview continues with more from the Drs Arole on how the Comprehensive Rural Health Project evolved over the years and especially on its impact on the caste system in the villages within the project area.

Contact: We've been discussing health care priorities at the first referral level and what number of people actually need referral services.

R. Arole: When you're considering providing the greatest good for the greatest number, how much do you take this into planning?

The whole issue in primary health care is the moral issue. The issue of equity and justice. And therefore when we planned our programme we said, "Who is our community?" We deliberately said our community is the poorest 50% among the population. Those are the people who are destitute. The top 20% of the population is knowledgeable, informed. They have money. They can find a way of getting health care. If a few of the more wealthy come and take advantage of our hospital, this is alright, but we shall deliberately reach out to the really poor part of the populace.

One cannot work for everybody, so therefore you must be selective. We decided to work among the poor because the chances of the poor helping other poor are greater. For 3000 years the high caste have always been against the low caste, so the chance of high caste people doing something for the low caste is minimal. Therefore the people with whom we deliberately got involved were from the lower caste. This is the whole question of equity.

The second thing is integration: integrating curative with preventive services. This was brought home to me. There was a mission clinic one to two hundred miles from here, staffed by very dedicated women nurses. I went there to help them. One nurse went to the village, giving medicaments and another nurse went giving immunization. So I went with this nurse. Early morning we went into the village and knocked at each door. The family opened, and the nurse said "We have come to give you injections." "But, sister," they said, "this child has diarrhoea, or he has a sore here." "Oh, don't tell me about that," the sister replied. "The other sister will come tomorrow and give you medicine."

It is ridiculous, but it happened all the time. So there has to be that integration of curative and preventive services. There also has to be integration with other sectors such as agriculture, water supply, environment, and education. These are the non-medical interventions that have a direct effect on health.

Contact: Can we talk about the non-medical programmes that you have developed with the community?

R. Arole: Let's take agriculture. The biggest problem in this area is water. The rainfall here is about 30 cm per year. So first of all we want to make sure that we harvest the water. In the beginning we built small "check" dams to catch the water from the smallest streams. And then we dug big open wells, so that the water that percolated into the ground could be taken out and used. The Watershed Programme includes water harvesting, water preservation, and water management. Then, if a crop was going to grow, the land had to be levelled. This called for contour bunding and other agricultural operations. Then you do something about erosion. So after this programme we started reforestation. The people have planted nearly 10 million trees as part of our Healing of the Land Programme, which is a sub-programme under the Agriculture Programme.

But before anything happens in a reforestation programme, before you get any product from the trees, grass begins to grow in the protected area around the trees. And because animals are not allowed there, the grass grows tall. In India, as soon as the grass grows out of the soil, the animals come to eat it. Now, for the first time, the people saw the grass growing three feet tall. They were wonderstruck. So even before the trees grew, there was grass available for fodder. So dairies started. One village now produces some 4000 litres of milk a day and another some 600 litres a day. This started as an offshoot of the Reforestation Programme.

The programme also works to develop useful alternative crops. For instance, formerly thevillagers would grow only the cereals that they eat. So through the Agriculture Programme, legumes, vegetables, and different oil seeds were introduced in the area. As part of the Reforestation Programme people have started growing fruit trees, like the Indian plum and mango, and local varieties they had not been growing.

In all this, it helped that every three months we organized a seminar for farmers, inviting different resource people, but mainly other successful farmers who taught the people their techniques. This is a very barren area, but there was one farmer, for example, who really succeeded in growing grapes. Every time he came to the seminar he told about how he made money growing grapes. Grapes are not a particularly nutritious food, but he was making money. That man began with only two acres of grapes. Today in that area, there are 150 acres under grape cultivation.

M. Arole: In regard to other programmes, the creation of dairies led to the Dairy Programme, which in turn led to the Veterinary Service. In each village there is now a man trained as a primary veterinary worker. This then led to the Poultry Programme and the Animal Husbandry and Vaccination Services.

You've got to understand that community participation has been central at every step. No programme was imposed on anyone. It is really when you sit down and talk and when you work together that people express their needs. Together, we try to find solutions.

Contact: What if the needs that they express are different from the needs that you perceive?

M. Arole: Then we try to find the needs they express that are more or less the same as those we perceive. For example, the people's expressed need was for water. But we perceived lack of water not as lack of just any water, but lack of safe drinking water. So that's an area where we came together. It was a starting point in the whole discussion of water. Then there was food. To them, it was any food, but for us it was nutritious food.

So these are the common points where we can get together. And of course when you talk about food and nutrition, many avenues open up. Then you go on to the whole question of food production and availability. Food availability leads to the whole question of justice because one must ask to whom that food is available. So it comes to economics, and then to why people are poor. It comes to the whole issue of the caste system and to the fact that within the family the food is less available to the women, which raises the whole question of social status and the place of women in the family.

We have the two working groups in the villages, the women's group and the farmer's group, in which we are having discussions about these things to try to find solutions. And it is they who are suggesting solutions. Each village then goes its own pace. It's not that we have a programme in all the villages. It's not like that. Each village perceives its own problems in its own way, and so each addresses its problems in its own way.

R. Arole: We have identified certain constraints to community participation. I think that nowhere in the world is there a caste system such as that which exists in India. It's so oppressive. And it ensures that the poor remain poor. So first we really attack it, and we conscientize people against the irrationality of the caste system. But in the beginning we had to do some definite diplomatic things. For instance, we ensured that our food-for-work programme was managed by the poor people in the village. For centuries, the low caste, the untouchables, had never had an opportunity to take part in any decision making. We made sure that they took charge of our food-for-work programme.

Now we're talking about a programme that had as many as 2000 people working in it, and the poor people were deciding which land would benefit from the work. Never in their lives had they experienced such decision-making power. It also meant that the existing power structure was going to be hurt, and the local elite was not going to keep quiet. The only reason that we survived in this thing was the tremendous skill that we had between the two of us in surgery and medicine. The elite realized that if they didn't allow the programme to go on, then they would lose very good doctors. In that way, our curative experience and skill came in very handy in keeping us from being uprooted from here. If we had not been doctors I don't think we would be here today. This is something positive about the medical profession. You can use it.

Because water had been a priority identified by the community, our first big programme was the drinking water programme. Here again the caste system comes in. Where do you put that tube well? The high caste people want it in their area, but the low caste people know that if the well is in that area, they will not be allowed to draw water. So we asked the geologist to go around the village doing his testing but ultimately to zero in on an untouchable area. But this was done slowly. Over a period of months, we put in 140 wells. Only later did the high caste people realize what had happened.

At first, caste problems also prevented community participation in the training of village health workers. When the village women first came for their training, the high caste women refused to sit with the low caste women. The low caste women would not even sit on a carpet. They sat to one side. So we integrated them. We had them cook together.

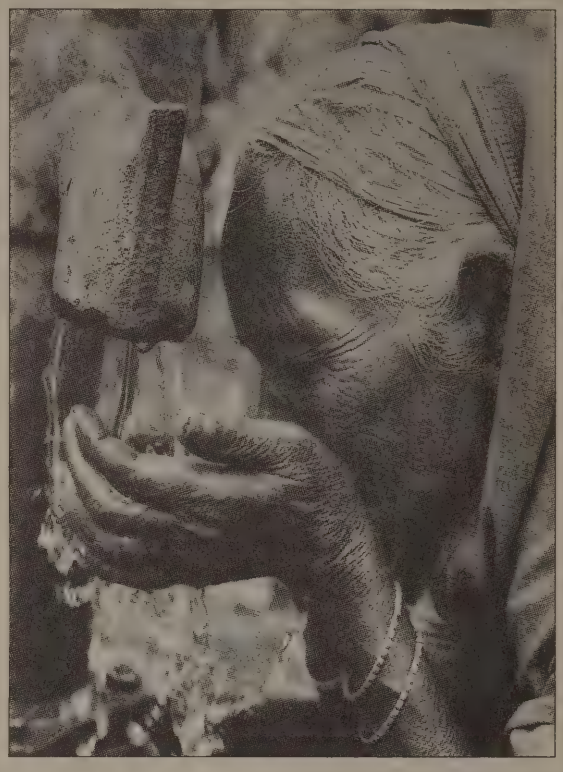


Photo: WHO, A.S. Kochar
Access to water—one of the most fundamental human rights—is often denied to the poor.

Some of the high caste women left because an untouchable was cooking. We had them sleep on the floor on a big carpet and covered them with a single blanket so for the first time they came into physical proximity with one another. And we would take them to the hospital laboratory and draw blood from their fingers and ask, "Is the Muslim blood green and the untouchables' black? Haven't we got the same red blood? And don't we have the same kind of heart?"

Because we started doing that right from the day we came here, it has spread tremendously. The first thing has been that all caste groups work together. We have not planned inter-caste marriages, though that has happened once. Caste is a major issue that divides people, and once it is gone, people are able to work together. Caste is such a big thing that politics, class structure, job, education become almost insignificant dividers. □

In their absence, the work at Jamkhed continued and was even expanded into a new area, 150 km away in the mountains of the western Gaghts. There the villages lie in valleys so deep that some rarely see the sun, and drought is a problem because rainwater runs off the steep slopes before it can be retained. First into these villages from Jamkhed, after the necessary introductions to village leaders, were the experienced village health workers—building bridges first from woman to woman and then from village to village in a way that health professionals from the outside never could. □

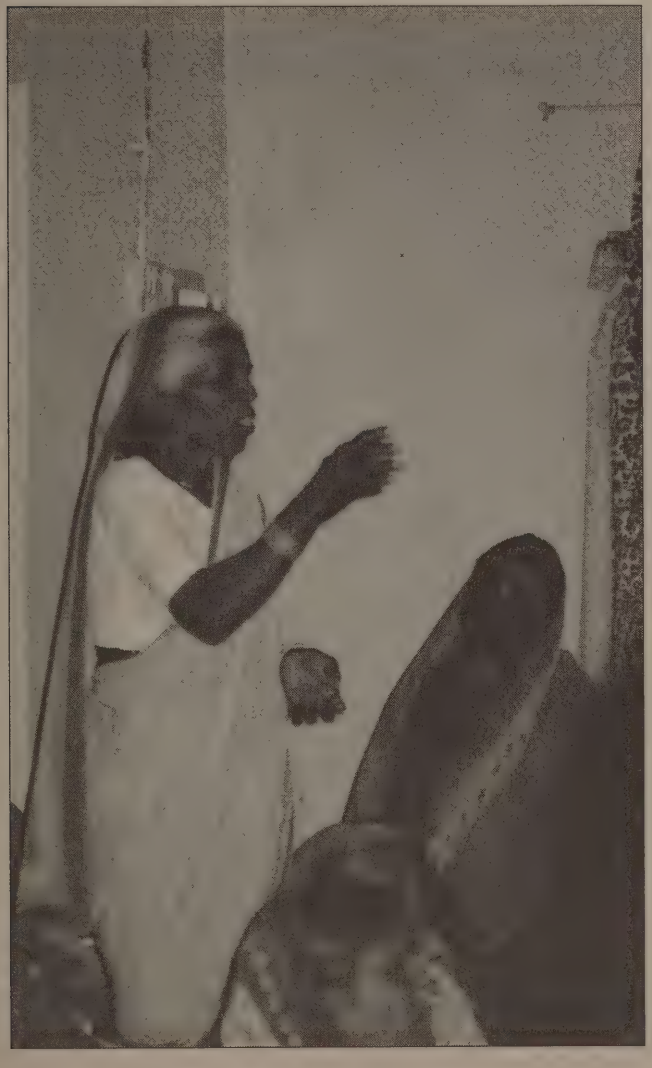


Photo: C. Jagel

A recently trained village health worker from the mountainous region of the western Gaghts, a new area into which CRHP has recently expanded, explains her work to a group of health professionals and development workers.

Our interview with the Aroles covered numerous topics, regretfully too many to include them all here. However, we felt that Contact *readers would be interested in the following discussion of values—for example, solidarity and selflessness and a sense of mission—as they have related to the programme at Jamkhed. The topic arose in the context of a discussion of nurses, who had proven ineffective at the village level but became the backbone of the hospital structure.*

R. Arole: Giving good training to nurses, therefore, has been very, very useful. You see, we first made the big mistake of training the doctors, and the minute they acquired the skills they left for private practice. But the nurses didn't leave. Now I don't teach anything to the doctors; I teach everything to the nurses.

Contact: This may sound naive, but I thought staff were attracted here because they wanted to serve.

R. Arole: In fact, it is very difficult to get doctors and nurses or clerks to come to a remote place like this. Many professionals are more interested in earning money.

Contact: What about the Christian idea of mission?

R. Arole: Some of the worst are Christian medical doctors. I went for the government of India to examine 16 medical colleges to find out what they were paying their doctors. I had wonderful talks with students and interns in government medical colleges who said that they realized the poverty in this country and that they were meant to serve, so they would serve the government for two years and then find something else. But when I went to the three Christian medical colleges the students said,

"We have paid a lot of money to get our training, and we must get that money back. And we must also get our post-graduate training before other doctors come and start their practice." Not a single one said, "I want to go and serve in a mission hospital." Then I asked, "What about all the lofty things that you said [in your applications] about wanting to serve humanity?" and they said, "That was only a way of getting in."

M. Arole: I have just met with the director of Christian Medical College, Vellore, who said that out of 60 graduates every year, only three or four go to serve in a mission hospital. Unfortunately, community health is considered the poor cousin of the medical profession. It's not glamorous.

R. Arole: We have found that lofty ideals about doing things for others are not the prerogative of the professionals or educated people. On the contrary, simple, illiterate people, proportionate to what they have, are much more self-sacrificing than we are. So they can be inspired and motivated to do a much higher thing than we are doing. And this is where the real success lies. It has to be purposely cultivated. It's just like any other skill that you cultivate in people. It also is a skill to be caring for others. And that is why when some people talk to the [village health workers and village women's groups] about what they have learned through their activities, they say, "The first thing that we learned is to love. Formerly we didn't care for each other. And after all, what is love but caring." But this has to be taught. One need not be modest or secret about it.

Fifty percent of our time is spent on technical things, but the other 50% is spent on values. And this is where the Christian message comes in: development without values is meaningless. We come back to spirituality. Not the narrow spirituality of whether you are saved, not that kind of nonsense. Rather spiritual formation and spirituality in the sense that spirituality begins when you stop thinking about yourself and start thinking of others. To develop these spiritual values, you stop thinking about yourself and start thinking of others. This explains what has happened to the medical profession. When doctors do not have values they become butchers.

Values have to be incorporated in a training programme. And these values have to be transferred to other people. The whole concept of development of health care then is not just giving things. It's a matter of changing attitudes. Therefore, it is the development of the human person rather than the development of things. Health and agriculture are actually secondary. The primary thing in the development of a person is changing attitudes. □

Photo: C. Jegel

Health development is a matter of changing attitudes, conclude the Drs Arole. Here a young girl listens intently as the village health worker of her village speaks to a group of health professionals.

TOWARDS COMMUNITY-BASED ACTIONS FOR HEALTH—

THE RADICAL EVOLUTION OF A HEALTH DEVELOPMENT PROGRAMME AT DEENABANDU, INDIA

An article on the community-based programme in Deenabandu, written by the co-founders of the programme Drs Hari and Prem Chandran John, first appeared in Contact *in December 1984* (Contact *No. 82). It provided a refreshingly frank look at the evolution of a community-based programme over its first decade. The authors entitled their article, "We Learn Through Our Failures." At that time they described Deenabandu as a programme that had "grown along classic lines. It started as a 'service for the needy,' health-delivery type of unipurpose programme, and through many stages it has finally evolved into a programme that aims at structural changes in society that will bring about social justice."*

In fact, from the time that this statement was written the programme has continued to evolve. Now nearly another decade later we return to Deenabandu to follow its more recent developments. We find that the programme has taken increasingly radical turns in search of the most effective strategies for community empowerment.

The story of Deenabandu actually begins in 1947 with a young Indian pastor, inspired by Gandhi and filled with a desire to make his religion practical. With 2000 rupees given to him by the South India United Church (now the Church of South India) the young pastor and his doctor wife founded Deenabandupuram, "Village of the friend of the poor." Deenabandu's early accomplishments were true to its missionary nature: medical work, especially among leprosy patients; a school and an orphanage; and a small agricultural programme. The Deenabandu mission grew into a large multi-sectoral programme—the Rural Life Centre—which is still a strong presence in the area.

The young pastor was the father of Prem Chandran John, co-founder with his wife Hari, of the community-based health care programme in Deenabandu. Hari and Prem John are graduates of Christian Medical College, Vellore. Following their graduation, in 1969 they came to Deenabandu as medical doctors to work within the mission programme. In 1971, a full-fledged mission hospital was built as part of the Rural Life Centre, and it became known for excellence in curative care.

In their *Contact* article of 1984, Hari and Prem John looked back on their early years at Deenabandu:

> The period 1969-1973 saw extensive curative services offered at the Centre, coupled with a mobile clinic that took "modern medicine" into the villages. This was also a period when many assumptions were made that were to have considerable influence, both negative and positive, on the programme that followed. This was the time when we arrived to work in Deenabandu.
>
> Having just graduated from a prestigious medical school, we assumed that we knew better than the community what their needs were. Therefore, planning of programmes was based on our own perceptions. Our sophisticated medical education also taught us to look down on anything indigenous, and an over-reliance on technology handicapped us in village conditions.
>
> A total lack of training in social sciences kept us in ignorance of the complex interactions between various forces within and without the community. We were totally unaware of the true socio-political situation in the country, and we were unable to see the true cause of ill health in communities, which is poverty. Our education had not prepared us to face realities in rural India.

Photo: WHO

Medical training most often does not prepare a doctor for the reality of life in rural India, nor for the types of non-medical interventions, such as education, that will have a long-term effect on health, as Drs Hari and Prem John discovered.

The realities of life in the rural area of Deenabandu at that time were similar to those in the area of Jamkhed, described earlier in this issue. The infant mortality rate in the villages around Deenabandu in 1973, for example, was 127 per 1000 live births. Located 120 km west of Madras, the Deenabandu area is characterized by broad valleys broken by cone-shaped hills. The hills, once forested, are now barren. The valleys between the cone-shaped hills are fertile, but they are planted mainly with export crops: rice, peanuts, and sugar cane (the production of which is government subsidized). Forty percent of the population is composed of harijans, and 40-45% is landless or left with only the eroded land on the steep hills. Benefits from the sale of export crops generally do not filter down to the landless and disadvantaged.

As the realities of life in rural India and the inherent limitations in curative care dawned on Hari and Prem John, they began a personal and professional evolution which would radically affect the programme at Deenabandu. Hari John spoke of this period of discovery in an interview with *Contact* (see box).

In February 1992, Contact *visited the Deenabandu Training Centre and there interviewed its co-founder Dr Hari John. In the excerpts from that interview that appear below, we discuss the evolution of Deenabandu from a mission hospital to a training centre for health development, and some of the discoveries made by the Johns along the way.*

H. John: When we came here in 1969, health was a programme under the Rural Life Centre, which was affiliated with the Church of South India and funded from abroad. Prem was working among people with leprosy and I was doing family planning and general practitioner's work. I also had a very successful private practice in R.K. Pet [the closest town]. Through my private practice I established my name and became well known in the area. We also had a mobile clinic.

In 1973, Prem received a scholarship to study public health at Johns Hopkins. During this time, I did family planning in the U.S. When we returned to Deenabandu we set up a separate unit for health because we no longer believed in the old approach. We wanted to do community health. We had seen the futility of providing just curative services, especially if you are interested in the really poor in the community. That's when you see that the people who use your services are not the poor.

We broke off from the Rural Life Centre because we felt that the benefits of that set up, which covered the whole community, were reaching only the rich. We also wanted to set up a community

health centre and manage our own funds. One of our donors, World Neighbors, was willing to follow us into this. This was also part of their evolution. In 1974, we started community health, though we didn't know how to do it.

Contact: I wonder if anyone knew how to do it.

H. John: Exactly. We only knew that there were barefoot doctors in China and that the Aroles had started their work. They were our only models. Johns Hopkins had been mainly theoretical. We really experimented out there.

Contact: How did you experiment?

H. John: With village health workers, for example. Our first thought had been that we should find out all about the diseases and then teach the health workers and give them a drugs kit for treatment. So we went to the [village councils] and explained what we wanted to do. We said we wanted to train health workers to be available in the villages. So all these council members started choosing their relatives. So we had a lot of high caste people and very few from the lower castes.

When these people came for training, we made high and low caste trainees cook and eat together. That was really the first move in breaking down the caste barrier. If a trainee didn't want to mix, we said, "Look here, if you don't want to mix here, how are you going to serve the outcastes in the community. If this is really impossible, instead of us letting you go, why don't you save face and drop out, saying that you don't like the training." We had to eliminate people like that. Out of about 20, five or six dropped out.

At the same time, we had to scout around to find people from the outcaste section who we thought would be capable. We just explained to the village leaders that we needed such and such a person. They were very keen to have our services, so we could do that. They even provided us with buildings in which to conduct our mobile clinics. But then we asked ourselves, "Why should these poor people have to come to the high caste village for our services? If the high caste people want our services, they should come to the low caste village. If the low caste village cannot provide space, then we should conduct the clinic under the trees." We realized we had made a mistake by locating our clinics in high caste villages, so we corrected that.

Contact: How did the high caste village leaders take this?

H. John: Oh, they murmured a bit and were unhappy about the change, but they couldn't do anything about it. They still needed our services.

Contact: At any time did you get all of the community together to talk?

H. John: No. We went around and talked to people. It would have been possible, but then we would have had to go to the high caste village to do it.

Contact: So it was better to do this more quietly?

H. John: Yes. So then we trained the women, gave them medicines, and they returned to their villages. But then we found that people were not using their services. That was most interesting. We asked ourselves why. Then we discovered that these people have a health care system of their own. They know how to use herbs and massage techniques.

Contact: Are you referring to traditional healers?

H. John: They were not traditional healers. Each elder in the household knew something. They had some knowledge of how to take care of

simple things, and we had ignored that completely. So this was the next experiment. We started learning from them, asking, "What is it that you do?"

This was in the late 1970s. For treatment of cuts, for example, we had used tincture benzoin and an antiseptic powder, but we switched to a remedy made from a local berry, Terminalia chebula (black myrobalan), which was crushed and put on the cut. The village health workers now have this powder in their kits, and when someone comes with a cut, they put it on, bandage it, and tell the person not to let water touch it. It heals beautifully. Then they teach them what it is.

Contact: But first they apply it without saying what it is?

H. John: Yes, they have to. They have to prolong the mystique just long enough to introduce it, to have it accepted in the community. I learned this from the village health workers.

The village health workers are always very smart when introducing anything new in their areas. For example, they had earlier introduced Vicks VapoRub. The villagers love ointments for headache. Everybody who had a headache wanted this Vicks on their temples. When we took the next step of not ordering any drugs from the U.S., people were still coming for ointments, so the village health workers made a camphor ointment and put it into the Vicks bottles. When people came for ointment they gave this. When people asked why the mix was so watery, the village health workers replied, "See, these Americans, they have decided to make this watery type of thing, so it's watery Vicks. The people accepted it. They applied it and it worked. The next time they came back, the village health workers said, "It's not Vicks, and we'll teach you how to make it."

Contact: Was this a process of weaning people from Western medicine?

H. John: Yes, and this is the way the village health workers accomplished it.

Contact: What was it like to admit to them that you had made a mistake and wanted to revert to herbal remedies?

H. John: It was hard in the beginning because we had been the very people who had come and said, "This is wrong. That is wrong. You should do this instead." And now we were changing our minds. It took a certain amount of faith on their part to follow us in this new approach—faith in the fact that we were doctors. We had to say to them, "You can make mistakes, and we, with all our education, can make mistakes." Now we believe in it, and we also use it.

Contact: This probably caused a revolution for a doctor to admit to making a mistake.

H. John: Exactly. We did pretend many times that we knew. That is why now, when a village health worker tells me something I think may be a superstition, I don't say anything. I ask why and think that she might know something.

You see, we had begun to ask ourselves, "What is it that the people do when they are not using our services?" Then we found that they would use a particular herb or a special massage. If it was an herb, I wouldn't know the botanical name, so I would take a sample to a botanist to have it identified, and then I would read all about it to learn its active ingredients. To my surprise, I found that the herb would contain the same active ingredients as what I was giving for the same thing.

Contact: Could you say that this learning process forced you into a more participatory approach?

H. John: Yes, except that at that time I didn't know what it was. □

Hari and Prem John had initially assumed that tackling the complex problems they were encountering in their work in Deenabandu "required well-trained professionals and that auxiliaries were not capable of doing meaningful work. The shift from our initial 'service delivery,' high technology, professional, scientifically planned type of programme to a point where we considered ours to be an 'enabling role'—enabling the community to live in health, using appropriate technology and appropriate levels of workers, and enabling true participation of the community in all levels of programme implementation—was long."

Determining the appropriate levels of workers for the Deenabandu programme was an ongoing process which began to crystallize in the mid- to late1970s. Initially, surveys of the local population and home visiting had been undertaken by auxiliary nurse midwives. By 1975, village health workers had been chosen, but health education in the villages was still carried out by the auxiliary nurse midwives. Through 1978, the village health workers acted mainly in support of the programme's curative services, as offered by the hospital and the mobile clinics. Mobile clinics were held on a regular basis, until, as the Johns explained in their 1984 *Contact* article, "we learned enough to see only those patients who were referred to us by the village health worker. The [mobile] clinics, though used as an 'entry point,' tended to slow the process of acceptance of the village health worker by the community, and we stopped doing them entirely after four years." It was in the late 1970s and early 1980s that the village health workers began really expanding their role. By 1981, they were handling 60-80% of the curative work. At that time they were using a selected range of Western medicines provided by the Deenabandu programme. By 1984, they had switched to herbal remedies, with the occasional exception of aspirin for fever.

The Deenabandu programme today places the village health workers and the *dais* (traditional birth attendants) at the front line of health development. They are backed by the programme managers, the auxiliary nurse midwife, and a staff nurse. There is no longer a doctor with the programme and the hospital no longer functions as a hospital. It has become a training centre for community-based health development. Although Hari and Prem John maintain an active interest in Deenabandu, the overall responsibility for programme management is now in the capable hands of Sister J. Jegannathan, formerly a nursing superintendent with Christian Medical College, Vellore. In the mid-1980s, the Johns decided to withdraw from active management of Deenabandu in order to free themselves for broader involvement in comprehensive health and development. Hari John now heads the Asian Network for Innovative Training, Research and Action Trust (ANITRA) and Prem John the Asian Community Health Action Network (ACHAN), both based in Madras.

The changes at Deenabandu, including the discontinuation of the hospital, meant adjustments for the many people involved or otherwise affected by the programme. For Sister Jegannathan, the transition presented certain challenges. She explained some of these to *Contact* in an interview during our February 1992 visit to Deenabandu (see box, page 20).

The village health workers also faced adjustments during this transition. In February 1992, ten Deenabandu village health workers, some of whom have been with the programme for 16 years, met informally as friends and colleagues with Hari John, who they had not seen for several months. At that meeting, some of them spoke of their reactions when the hospital had closed in the mid-1980s. Although they have since proven their competence in the absence of medical doctors—there have been only five referrals since 1986—they were sad to see Johns depart and give up the medical practice. To the latter, Hari John replied simply, "I have transferred my knowledge to you."

Among other things, the group spoke of their relations with government health services. This experience has been mixed. In the discussion that followed, they reported that people in their villages will not go to government doctors for injections because the doctors sometimes give "bad" injections. The people would rather pay a private doctor. Bushnam, a village health worker who has been with the Deenabandu programme for 16 years and who also undertakes surveys for the government health

Sister Jegganathan

Sister Jegganathan is a nurse by profession and a graduate of Christian Medical College, Vellore. After some previous experience in a rural development programme she came to Deenabandu as directrice in 1986. Despite her experience, Sister Jegganathan found that Deenabandu presented some new and unexpected challenges.

Sr Jegganathan: When I came here, I found the work was completely different from my former work as a nurse in a big hospital. I wondered if I would be able to manage. For two years I remained by Hari's side learning how to train health workers. I was always expecting her help, but she was very particular that I be independent and take over the management of the programme completely. At the end of that time, with Hari and Prem's encouragement, I had confidence, and I am now managing fairly well. I feel happy here.

Contact: Can you tell us about the period of transition at Deenabandu, after the hospital was closed.

Sr Jegganathan: The hospital personnel left, except for two of the nurses who continued with the community health programme. They are programme managers. The programme personnel now visit the villages not as a mobile clinic, but to coordinate and monitor the work of the village health workers. They back up the health workers and treat patients as necessary, but health care is offered primarily through the village health workers.

Contact: What has been the biggest adjustment for you and for the programme in this evolution?

Sr Jegganathan: For me the change was sometimes difficult. I had been a nursing superintendent, and I was very strict and disciplined in my work. Previously, for example, I had expected the hospital to be spotless for the doctors' rounds. Things like that. Hari and Prem would say to me, "Just pat people on the back," but it took a long time for me to change my attitude. This was the hardest thing for me. I discovered that the most important thing in getting the work done well was that people love each other. And when people made mistakes, I had to find another way of correcting them than pointing a finger.

It also took me a long time to accept the village health workers.

Contact: Do you mean the village health workers as legitimate care givers?

Sr Jegganathan: Yes.

Contact: Was there any particular breakthrough for you that you recall?

Sr Jegganathan: Yes, it was when we treated the young girl in the village of Lakshmi Reddi Palli [see page 23]. This was actually not long ago, in 1988.

Contact: What difficulties do you face in your day-to-day work?

Sr Jegganathan: It's very important that we change our concepts [about health development] and that we go live in the community. My project managers are supposed to live in the villages and work, but some of them have been here for a long time and don't find this necessary. Yet they need to live in the community in order to understand the people's problems. That's the real way of working.

Contact: This could be considered an on-going problem, then, getting programme staff—the more educated professionals—to live in the villages?

Sr Jegganathan: Yes, and this is really the greatest problem that we face in programme administration. □

service, related one case in which she had accompanied a person to the primary health care centre for a DPT vaccination. The injection point had later swelled. The doctor who had given the injection then said, "You know how bad government services are. If you want quality, you should come to me in the evening." The doctor had a private practice on the side and was stealing drugs from the primary health care centre for use in his practice. The women added that they now ensure that government nurses use proper sterilization procedures, and the health workers do the boiling of the needles for injections made when they are present. In the government hospital, however, it is the doctor who makes decisions, and they cannot do anything to influence his practices.

By 1984, Hari and Prem John had come to the conclusion that, despite the obvious deficiencies in the care offered by the government health service, government facilities should be used and should be made to improve.

We started with a base hospital providing secondary care. The hospital had a very busy and often lucrative practice. We found that we tended to spend more time "curing" people and slowly started de-emphasizing this aspect. The effective service carried out by the village health workers also diminished the number of people who need secondary care. We now believe that if enough preparation of the community is done, it should be possible to start programmes without base clinics, which are often a hindrance. We also believe strongly that existing government facilities should be used, and if they are inadequate, people should be organized to demand better services rather than duplicate services.

The Johns ultimately felt that curative services offered by the hospital and the mobile clinics were actually detracting from the main work of the programme, which was to benefit the poor and promote community empowerment. This

A meeting with the village health workers of Deenabandu

The village health workers from villages around Deenabandu gathered at the Deenabandu Training Centre on 18 February 1992. They had come to receive their monthly incentives (50 rupees), but also to see one another and to talk with Dr Hari John, who they had not seen for some time and with whom they clearly share a respectfully affectionate relationship. This also gave Contact *the opportunity to hear their stories, some of which are related below.*

Illustration from *Health for the Millions*, June 1991

Jalakshmi, who has been a village health work for 14 years, said that she had come to the area to marry a villager. As a young married woman, she could not leave her house, even to fetch water. Her husband forbade her going out, and she was shy, being new to the village. Jalakshmi knew only her direct neighbours.

Jalakshmi's second child was delivered by Chinta, a village health worker who has now been with Deenabandu for 15 years.

After a third child was born, Jalakshmi began venturing out of her house, just when Hari and Prem John were looking for health workers. Jalakshmi was recommended for training because she had previously had six months of teacher's training. At first her husband didn't want her to go out and so, for a period of one year, prevented her from undertaking the training. Jalakshmi had been so desperate at this point that she wanted to commit

could best be done through the village health workers. Over time, they also found that in order to have any impact on the situation of the poor, activities to promote community empowerment must specifically involve the poorest within the community. In 1984, they wrote:

> We started this as a total community programme, for the rich and the poor alike, for the upper caste and the lower caste, for we believed that we had a duty to all. During the initial stages, we found that the services offered by us were being extensively used by those who have land, money, education and who are often from the upper castes. This resulted in one of our primary objectives being fulfilled—to double income levels. A mid-programme assessment revealed that though we had largely achieved this objective, it was at the cost of the poor, who showed only marginal growth while the "haves" showed spectacular growth. This was evident in a dairy programme we initiated. This package programme involved bank loans for cows and feeds, fodder development, milk co-operatives and transport of milk to the dairy. Not taken into consideration was the fact that the landless harijans were not used to cows, had no place to grow green fodder, and if they had any milk, sold even the last drop to the dairy, while their children were malnourished. The land-owning classes, on the other hand, increased income levels significantly....
>
> This and other lessons made us resolve to work only with...the powerless: the landless and the harijans. All programmes—health, agricultural, animal husbandry, etc.—were offered exclusively to this group. The village health workers, too, served only them. Thus our focus became defined.

Although these words were written in 1984, the commitment of the Deenabandu programme to focus on serving the truly poor has only grown stronger since. From the 1979, as the chart on pages 26 and 27 shows, the accent of the programme was on serving the powerless but

suicide. He was persuaded to change his mind by Hari John.

After marriage, village health worker Chinta had worked in the fields as a labourer and kept house. When a government nurse had come to the village, Chinta had accompanied her on her rounds to learn midwifery, but her husband had beat her for this. Chinta, however, was determined to learn.

One day, when the government nurse was unavailable for a delivery, Chinta went instead. She continued to improve her skills as a *dai*. She was paid 2 to 5 rupees per delivery and a gift in kind. She told her husband that this contributed to their family income. He vacillated, but her father-in-law, who treated her badly and did not support her in her work, was like an angry bull. Finally she won him over. Chinta's husband now calls her a doctor.

On another occasion, Chinta had been at a government primary health care post when a woman arrived in the last stages of labour. The government nurse wanted to return home instead of stay for the delivery and said, "The baby looks big. I can't do that here. She needs to go to hospital." Chinta, who could see that the woman was about to deliver, asked the government nurse to examine her, and the government nurse replied, "Oh, you know so much, do you?" and locked them both out of the delivery room.

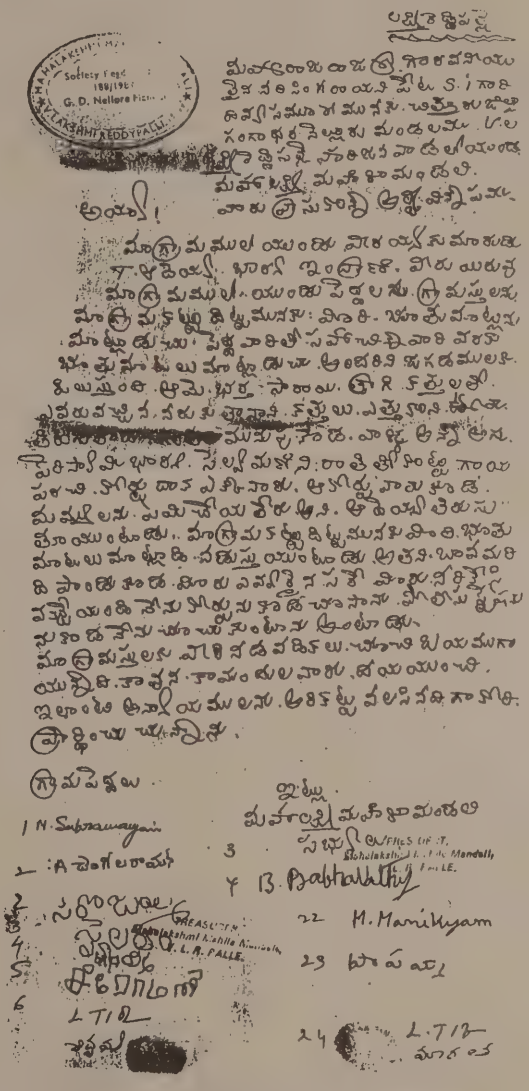
She hadn't locked the door properly, so Chinta tried the lock. The door opened, she put the mother on the delivery table, and the woman gave birth to twins immediately. The government nurse had been angry, but then the people finally protested and the nurse was thrown out of the health service. □

also on serving others as well. By 1984, the programme was serving *only* the powerless. Also during this time, the programme evolved to become more comprehensive, emphasizing not only health but the organization of women and youth, and the development of the community's critical awareness and ability to analyze their situation. The programme was experimenting with alternatives in health, education, and agriculture, and was placing greater emphasis on the environment. It had become clear that only through a comprehensive approach to development, which included health, could any radical change be made in the situation involving the poor. Hari and Prem John now term such a comprehensive approach *community-based actions for health.*

Strategy for expansion

This new comprehensive approach was applied when in 1988 the programme expanded into a new area, Lakshmi Reddi Palli, 35 km from Deenabandu. Lakshmi Reddi Palli had been selected on the basis of a sample survey that showed it to be chronically prone to drought, and the women in the area seemed particularly oppressed. A team composed of Sister Jegganathan and experienced village health workers from Deenabandu first went to the area by jeep. They were ignored by the local villagers. They returned several days later and received the same cool reception. The team began taking the public bus instead of the jeep to travel to the new area. The visits continued twice weekly for six months before the villagers of Lakshmi Reddi Palli began to open up to them.

Village health workers from Deenabandu would arrive and join the local women in their cooking. They would play with the children, wiping their noses and picking them up when they fell down. The breakthrough came when the village health workers treated a young girl for severe malnutrition and tuberculosis. To treat the malnutrition, they asked villagers for donations of food from which they made a nutritious gruel. They also treated her with drugs for tuberculosis. The girl recovered and the village of Lakshmi Reddi Palli began to trust the Deenabandu team. Later the team asked the villagers why they had at first not wanted to discuss the possibility of organizing the wommen. They replied, "Other people have already tried it, and besides, we thought you were just coming to evangelize." Once their suspicions had been laid aside, a women's group was formed, and the group chose women to be trained as village health workers.



The petition of the women's group of Lakshmi Reddi Palli and some of its 33 signatures.

During a visit by *Contact* to the village of Lakshmi Reddi Palli, the villagers spoke of a current problem they have and of the totally new way that they have dealt with it now that they are organized. When the husband and wife of one family in the village repeatedly used abusive language in public and threatened other villagers with bodily harm, the women got together and told them, "You cannot continue like this. If you do, we will ostracize you," which they finally did. The wife of the couple then officially complained to the police, saying that the villagers had beat her. The police asked the women's group to report to the police station. With newfound confidence, the village informed the police that the women were too many to come to them, so the police should come to the village. When the police did not turn up, the women's group composed a petition explaining events. Four of their members took the petition, signed by all the women, to the police. The police realized where the truth lay and informed the ostracized couple that they must rejoin the villagers on their terms or be arrested. The husband of the couple angrily threatened the Deenabandu representative, who he blamed for organizing the people to have the audacity to go to the police. The issue was due to be discussed at the next joint meeting of the farmers' and women's groups, who would decide the terms on which the couple could be readmitted to village life. They would perhaps be required to pay a fine. In any case, they would have to admit that what they had done was wrong.

Mary Grace

Mary Grace is a supervisor and trainer of village health workers. She has been with the Deenabandu programme for 15 years. As a young married woman Mary stayed at home with her six children. She says she was shy. But she would leave the home to take her children to the mobile clinics conducted by Hari and Prem John. When Hari John asked Mary if she would like to be trained as a village health worker, Mary said yes. Her husband was reluctant, but finally agreed.

Asked if she is still shy, Mary replies with a quiet smile, "No, now I'm a bold community organizer." First, her husband was jealous of her success. He was an alcoholic, and he would beat her. But Mary was happy learning to be a village health worker. When Mary became the president of the women's group of her village, she felt she was in a position of responsibility, and a woman of her stature could not have such a husband. So she spoke to him. He changed and is now proud of her. He no longer drinks. Now when she is late coming home, he waits for her at the bus stop and takes care of her.

Mary adds, with an almost imperceptible sigh, that she had a very hard life with that man, but now her life has changed. One evening her husband was late coming home. She put her children to bed. He arrived home drunk and wanted to set her on fire. He threw kerosene on her clothing and was lighting a match when she screamed for help from the neighbours. Without Hari and Prem John, she says quietly, she could not have overcome such problems. Now whenever Mary meets with a women's group where the women complain about their husbands, she tells them that they should change their husbands. When a man in the village is an alcoholic she will talk with him in his sober moments. Now there is less alcoholism in her village, and people come to Mary for marriage counselling.

Mary is a Christian, which made the villagers suspicious at first, but Mary's real problems were because she was an untouchable. When she was first called to care for high caste children she had to treat them by dropping drug capsules from a height, so as not to touch them. If she was thirsty and asked for water, she would have to drink from her hands. That was in the beginning, 15 years ago.

Also at that time, untouchables were not allowed to wear shoes. Whenever Mary walked through the high caste village she had to carry her shoes in her hands. Then she and another woman in her village put on sandals to see what would happen. People in the high caste village jeered at them but said nothing. Then Mary talked to the people about hookworm infection and how wearing shoes could prevent it.

Photo: C. Jagel

Mary Grace, a Deenabandu programme manager, at home with her husband and two of her six children.

Now high caste families come to fetch her when one of them needs treatment; they accept her into their homes, give her water in their own glasses, and sometimes give her food. Mary feels that untouchability is only with the very old people now, and not with the new generation. She feels that it is because of her work as a village health worker that the caste barrier in her village has been at least partially broken down, and adds, "When I became a village health worker with skills and knowledge, my status in life rose."

When there was an important memorial function in Mary's village at the time of Indira Gandhi's assassination, Mary was called upon to speak as president of the women's group. The high caste villagers came to see what she would say. They said, "This is Mary, so-and-so's wife," and they all wanted to see how much she had come up in life. So they began to respect her for the thoughts contained in her message. They began to know her talents. Now they all know Mary. □

Hari John pointed out that from the beginning the aim In the new area has been to work only with low caste villages, although high caste villages have requested their help. It will be up to the low caste villages, once empowered, to decide how and when to include the high caste villages in their organization. She continued:

> We begin [in a new area] by just sitting with the people and asking what their health needs are. This usually gets down to economics. They want money. In our old areas there are a lot of credit unions. So we took people from the new area to see how these other credit unions worked. And we took people from the old area to see the new area. This is cross-fertilization. We facilitate this coming together. Then we ask, "Is this something you want to do." If they say, "Yes," then we say, "Then you have to be organized."
>
> We also take health workers from the old area and send them as a peer group to talk to the women in the new area and say how good it is to be organized, how a credit union is useful, how they have bargaining power and don't have to borrow from the high caste people at high interest rates. It was this peer group that succeeded in Lakshmi Reddi Palli.
>
> I was looking at the map of this new area, where we are now experimenting with community-based health actions. We found that our approach in the old area was wrong. If you want to make these harijan villages into a cluster so that the people have bargaining power as labourers, there's no point in organizing a few here and a few there. You have to organize all of the villages in a whole cluster so that they can bargain with the high caste people in the area. They can then say, "No, we won't work for 10 rupees. You must raise your wage." If the high caste people can look elsewhere for labour, your efforts are undermined. We made a mistake in our first area, so the strategy we are using in this new area is different.

These may seem strong words, indeed, to a health professional who has not travelled the same path as Hari and Prem John. They are certainly a far cry from what most medical students are hearing in the classroom. For the Johns, however, Deenabandu has been their classroom, as they learned through trial and error the most effective strategies for community empowerment. Their priority now is to share these strategies with others on a similar path. □

The chart on the following two pages was drawn up for *Contact* by Hari and Prem John. In providing it they commented that the exercise provided them their first opportunity to sit down and map out their experience in this way. They highlight here the key elements of the Deenbandu programme in its 23-year progression.

THE PATHS WE HAVE TAKEN—THE EVOLUTION, HEARTACHES, AND TRIUMPHS

PROGRAMME NAMES	RURAL LIFE CENTRE		MEDICAL MISSION		TRAINING AND SERVICE CENTRE IN COMMUNITY HEALTH AND DEVELOPMENT			ANIMATION CENTRE
PROGRAMME ACCENT	DISEASE PREVENTION 1969-1972	DISEASE PREVENTION 1972-1973	DISEASE PREVENTION 1974-1975	HEALTH 1975-1978	HEALTH AND OTHERS 1979-1981	HEALTH AND OTHERS 1982-1984	COMPREHENSIVE 1984-1990	COMPREHENSIVE 1990 to present
PROGRAMME ELEMENTS	CURATIVE CARE AND MOBILE CLINICS SOME PREVENTIVE ACTIVITIES (IN WATER AND SANITATION)	CURATIVE CARE AND MOBILE CLINICS CONT. PREVENTIVE ACTIVITIES CONT. SPECIFIC POPULATION SELECTED, SURVEYED HOME VISITING BYANMs SOME HEALTH ED. BY ANMs	CURATIVE CARE AND MOBILE CLINICS CONT. PREVENTIVE ACTIVITIES CONT. SPECIFIC POPULATION SELECTED, SURVEYED HOME VISITING BY ANMs VHWs CHOSEN BUT HEALTH ED. BY ANMs	CURATIVE CARE AND MOBILE CLINICS CONT. WITH SUPPORT FROM VHWs PREVENT. ACT. CONT. VERTICAL PROGRAMMES WITH NEW INPUTS: IMPROVED SEEDS AND FERTILIZERS, APPLIED NUTRITION, DAIRY HEALTH ED. BY VHWs	60-80% OF CURATIVE CARE BY VHWs USING WESTERN MEDICINES VHWs SUPPORT SERVICES REFERRAL SERVICES INCOME-GENERATING ACTIVITIES WITH SECTORAL EMPHASIS HEALTH ED. BY VHWs	CBHC—CARE OF DISEASES OF POVERTY THROUGH USE OF HERBS, MASSAGE, AND OTHER PRACTICES FORMATION OF WOMEN'S ASSOCIATIONS AND CREDIT UNIONS INTERSECTORAL INTEGRATION	COMMUNITY-BASED HEALTH ACTIONS (CBHA)— CARE OF DISEASES OF POVERTY THROUGH USE OF HERBS, MASSAGE, AND OTHER PRACTICES FORMATION OF WOMEN'S ASSOCIATIONS AND CREDIT UNIONS CONT. SOME ORGANIZATION OF COMMUNITIES FORMATION OF ANITRA (1985) AND THE ALTERNATIVE DROUGHT ACTION PROGRAMME*	CBHA—CARE OF DISEASES OF POVERTY THROUGH USE OF HERBS, MASSAGE, AND OTHER PRACTICES FORMATION OF ASSOCIATIONS AND CREDIT UNIONS CONT. ORGANIZATION OF WOMEN AND YOUTH (AMONG POOR) TRAINING FOR CRITICAL ANALYSIS, CRITICAL AWARENESS PRACTICE OF ALTERNATIVES IN HEALTH, EDUCATION, AGRICULTURE, ETC. EMPHASIS ON ENVIRONMENT
ORIENTATION	UNIPURPOSE	UNISECTORAL	UNISECTORAL	SECTORAL/ VERTICAL	TOWARDS MULTISECTORAL	TOWARDS INTERSECTORAL	INTERSECTORAL	INTERSECTORAL
TARGET GROUP	WHOLE COMMUNITY	WHOLE COMMUNITY	WHOLE COMMUNITY	WHOLE COMMUNITY	ACCENT ON POWERLESS	ACCENT ON POWERLESS	ONLY POWERLESS	ONLY POWERLESS
PARTICIPATION OF COMMUNITY	NIL	NIL	SOME	SOME	OVER 50%	OVER 50%	OVER 70%	OVER 90%
IDENTIFICATION OF PRIORITIES	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT & COMMUNITY	BY COMMUNITY	BY COMMUNITY
PLANNING	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT	BY P. AND C.	BY P. AND C.	BY COMMUNITY
IMPLEMENTION	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT	BY P. AND C.	BY P. AND C.	BY P. (?) AND C.
MANAGEMENT	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT	BY P. AND C.	BY COMMUNITY	BY COMMUNITY
FINANCIAL MANAGEMENT	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT	BY PROJECT	BY P. AND C.	BY P. AND C.	BY P. AND C.
SUSTAINABLE?	NO	NO	NO	NO	NO	YES (?)	YES	YES

PARADIGM SHIFT				
	MEDICAL CARE	HEALTH CARE	HEALTH ACTION	ALL ACTIONS LEAD TO HEALTH
	ACCENT ON DISEASE, DRUGS, AND CURATIVE CARE WITH SOME PREVENTIVE INPUTS	ROLE IN PROVISION OF SERVICE WITH INPUTS FROM OUTSIDE	USE OF COMMUNITY RESOURCES AND BEGINNING OF COMMUNITY ORGANIZATION APPROACH	BUILDING OF CRITICAL AWARENESS COMMUNITY ORGANIZATION ONLY
STAFF	PROFESSIONAL: DOCTORS AND NURSES	DOCTORS, NURSES, VHWs AND OTHER AUXILIARY STAFF (IN AREAS OF AGRICULTURE, DAIRY FARMING, WATER DEVELOPMENT, ETC.)	VHWs AND COMMUNITY VOLUNTEERS WITH NURSES PROVIDING BACK UP	
TRAINING CONTENT		DISEASES, WESTERN DRUGS, SANITATION	CURATIVE CARE USING HERBS; SOME INFORMATION ON CREDIT UNIONS	ALTERNATIVE SOCIETY, CRITICAL AWARENESS, ENVIRONMENT, WOMEN, ORGANIZATION, APPROPRIATE HEALTH, AGRICULTURE, ETC.
METHODOLOGY		TEACHER-TAUGHT	TWO-WAY PROCESS	PARTICIPATORY

* When ANITRA was formed and the Alternative Drought Action Programme initiated, programmatic emphasis was on development of land, water, and forest resources. A subsequent self-evaluation revealed the mistake of such a limited approach and the programme thereafter became more wholistic, covering health, agriculture, women, and education. The Women in Development programme was started in 1987.

Photo: C. Jagel

VHWs eating together in the former operating theatre (note the raised electrical outlets) at Deenabandu.

ONE BIG WHITE CANVAS—
LESSONS LEARNED FROM OUR TRAINING EXPERIENCES AT THE ASIAN HEALTH INSTITUTE, AICHI, JAPAN

By Yoshi Ikezumi, Executive Secretary, Asian Health Institute (AHI).
Established in 1980, AHI is a training institute for workers dedicated to health and development in Asian countries.

Illustration: From the AHI publication *Towards Justice Through Health*

INTRODUCTION

We have been using the participatory training methodology for the past five years, learning its principles and practice in different countries by observing and exchanging experiences with our counterpart organizations and other NGOs, by reading participatory training manuals, and by learning while actually doing it. Paulo Freire's philosophy of education has had a great impact on us and on many of the organizations we know that are using the participatory methodology.

We feel that what we have learned and put into practice through AHI's training programmes we owe greatly to the pioneers of the participatory training methodology in the so-called developing countries. The attempts to focus mainly on participatory approaches to research, training, and development at the grassroots in the developing world represent a divergence from the traditional top-down approaches of the so-called industrialized developed world—the capitalist West and the former European socialist bloc. These participatory approaches may represent a new type of ideology.

We hope that this developing ideology of grassroots participation, no matter what name it may be called, will challenge the ideology of the free market, which provides for the privileged few while impoverishing millions and contributing to environmental destruction. We hope that it will offer alternatives that are more humanizing and liberating. Finally, we hope that the continuing conflict between top-down and bottom-up ideologies and approaches will help to prevent further social and environmental deterioration and will help to make a more decent world for the impoverished majority.

The mission of AHI is embodied in the slogan, "Sharing for Self-Help." If we are genuinely interested in the philosophy of sharing for self-help, then we must start with this basic principle in all of our activities, with participatory training at the centre. Allow us to present a brief outline of the lessons we have learned in the process of using the participatory methodology at AHI.

LESSONS

"There is no teacher here, but..."

Not a few participants in our international seminar workshops have asked us beforehand for the curriculum and timetable of activities. Not a few have been surprised when we tell them that "we," the participants together with the facilitators and resource persons, have yet to produce the curriculum and timetable. We feel that workshops start with a "big white canvas" for the participants to paint on. The canvas, however, has some predetermined dimensions, including 1) a theme, for example community organizing, popular theatre, development education, or leadership for health; 2) a time frame, usually four to five weeks; and 3) the workshop location, Nagoya, Japan, which is far from the field situations of the participants and helps them to view their respective work and social conditions objectively. For the first one to two days of the workshop, participants outline activities and a detailed timetable (see Table 1).

Sharing is learning

The participants begin their learning experience in the workshop by sharing their own experiences in their respective communities and organizations. Facilitators and resource persons help to manage the flow of communication among participants. The learning experience can only happen if the participants learn to share honestly among themselves, to listen to what others have to say, and to express themselves freely (each is responsible for his or her own learning).

Table 1. An example of the outline of the International Seminar Workshop on Community Organization for Formulating Alternative Health Programmes in Asia (25 Sept. —28 Oct. 1989, Nagoya, Japan)

PHASE I (25-28 Sept.) WHERE AM I?

Structural analysis
- orientation/introduction
- organizing the course
- sharing of "self"
- sharing of organization
- structural analysis (village level: problem identification, etc.)
- principles (primary health care)

PHASE II (29 Sept.-10 Oct.) WHERE AM I GOING?

Goals and visions of development
- structural analysis (root causes of ill health and poverty)
- country sharing (macro situation)
- goal and vision of development

PHASE III (11-15 Oct.) HOW DO I GO?

Approaches to development
- three case studies for analysis
- synthesis of approaches to achieve the vision and goal of development

PHASE IV (16-21 Oct.) HOW DO I/WE DO IT?

Role of the community organizer
- roles of the community organizer
- leadership function
- management of projects/programmes
- community motivation
- objective setting and planning

PHASE V (23-28 Oct.) WHAT SHALL I DO?

Back home action plan
- developing action plan (decision-making session before implemention)
- overall synthesis
- overall evaluation
- closing programme

Starting with what we know, building on what we have

The participants' expectations for the workshop, together with the experiences they have shared, form the building blocks of the workshop. Resource persons provide additional experience to enrich the learning situation.

THE CONTENT EMERGES FROM THE PROCESS

In our practice of the participatory methodology, we try to emphasize the process of interaction among participants, from the time that we set the specific objectives and goals of the seminar to the dividing of tasks in facilitating, record-keeping, logistics, and cooking. When each participant helps to formulate the activities, there tends to be a high degree of attentiveness and participation. This follows a basic principle, put this way by David Werner: "When we listen, we sometimes forget; when we see a picture, we tend to remember; when we do it ourselves, we understand more; but when we discover it ourselves, we definitely use it."

The workshop context gradually emerges from the process, in contrast to the spoon-feeding methodologies that are characteristic of the "banking" approach to education. See Table 2 for a comparison between the banking approach and the problem-posing (participatory) approach.

THE GOAL: NOT JUST TO INCREASE KNOWLEDGE, BUT TO CHANGE SELF, SOCIETY, AND ENVIRONMENT

We would like to believe that the training we offer at AHI is aimed not just at increasing knowledge, but at providing a venue to share concrete experiences and insights; successes and failures and shortcomings; as well as dreams, visions, and concrete alternatives and action plans to promote the transformation process, starting from oneself, in the struggle

to improve the quality of life at the grassroots. The training process is aimed at initiating self-change, at renewing the conviction to be of greater service to people, through an attitudinal change and the sharpening of the critical faculties and understanding of social phenomena. There can be no social change without self-change within those who are the catalysts of social change and also within the people who are the subjects of social change. We are speaking here of an education process for liberation, based on Paulo Freire's *Philosophy of Education.*

Table 2. A comparison between the "banking" approach and the problem-posing approach used in participatory training methodology, based on principles derived from Paulo Freire

BANKING APPROACH	PROBLEM-POSING APPROACH
Teacher seen as possessing essential information	Facilitator provides a framework for participants who are thinking, creative, and active to consider a common problem and to find solutions
Pupils seen as "empty vessels" needing to be filled with knowledge	Facilitator raises questions: Why? How? Who?
Teacher talks, pupils absorb passively	Participants are active, describing, analyzing, suggesting, deciding, planning

DIFFICULTIES WE HAVE ENCOUNTERED

We have had our own share of difficulties in practising the participatory methodology at AHI.

Facilitation or manipulation?

The role of the facilitator is an important one, and his or her work is beset with many challenges. Among them is the tendency to manipulate discussions towards the facilitator's own views or agenda. Unless the facilitator always bears in mind the importance of the process rather than the content, such manipulation results in another experience in the "banking" system of education.

The language obstacle

Another constraint to learning in our experience has been the medium of communication in our international seminar workshops, which is commonly English. This presents a serious problem, both linguistic and cultural. Each participant is at a different level of English language ability. On the other hand, this language obstacle can become an advantage. How? By recognizing these differences in language ability, the facilitators, resource persons, and participants try to speak slowly and carefully, aiming to get their messages across. The listeners also pay greater attention to what is being said.

Achievement at the expense of the participatory process?

In addition, there is the tendency to be achievement- or result-oriented, at the expense of the participatory process—a weakness similar to that of manipulation in facilitation. A constant reminder for the facilitator should be the concept of the training process as a process of planting seeds, which grow progressively under the proper conditions, in the spirit of St Paul's words in his First Letter to the Corinthians (3: 6), "I planted, Apollos watered, but God gave the growth."

POST-TRAINING FOLLOW-UP

During the post-training period, AHI provides moral, rather than material support, through small but meaningful gestures such as sending birthday greetings, making on-site visits, exchanging newsletters, sponsoring consultations or AHI alumni homecomings in the participants' respective countries or regions, encouraging participants to write about their experiences, and publishing their contributions.

From time to time, former participants are invited to be resource persons for AHI international seminar workshops, and for the development education programme that AHI has initiated to help Japanese people learn more of the Asian reality.

The training period is never an end in itself. The post-training activities of each participant, based on his or her own action plans, become the real test for growth, for change, for transformation both individual and collective. □

DAVID WERNER ON THE EVOLUTION OF PRIMARY HEALTH CARE AND COMMUNITY PARTICIPATION

In preparation for this Contact *two-part series on leadership and community participation, Margareta Sköld interviewed David Werner, author of* Where There Is No Doctor, *during a CMC Think Tank for Latin America, held in Quito, Ecuador in December 1991. In* Contact *No. 127 we printed excerpts from that interview that focused on leadership for health. Below we share further excerpts, focusing on the evolution of primary health care and community participation.*

Sköld: We have published several of your articles in past issues of *Contact.* In an article published in 1982 you analyze the situation of rural health programmes in Latin America in regard to community participation. How do you see the primary health care movement today as compared to, say, 10 years ago? How has it evolved? And have your ideas about PHC changed over the years?

Werner: Well, from our experience in Mexico in exchanging ideas with many different programmes working at the community level, we began to feel that it is very important that community-based health care be linked with popular movements, with people struggling for their rights in areas that affect health but are outside of the health care arena, rather than simply concentrating on community work with a focus on health care.

I still feel that health care can be an entry point for working towards change in the larger sense, but it can also become a trap when people begin to focus narrowly on health and fail to deal with some of the underlying issues. In fact, health care as part of PHC has been used by a lot of the power structures as a pacification programme rather than an entry to a process for liberation. We see so often that governments have used the Alma-Ata thesis of PHC and misused it in order to co-opt grassroots programmes that have really grown up from the people, saying, "You have to fit into our structure."

Another big problem has been the corrupting of non-governmental programmes. US AID now provides funding for around 70% of the NGOs in the United States, for example, and once a programme receives such money there is pressure to emphasize family planning, for example, or selective PHC, and so on. With the build-up that UNICEF and WHO have given to some of these approaches, many NGOs have moved towards a more vertical or selective approach in PHC without analyzing enough what its real impact on community processes are.

Sköld: I have heard you using the term PHC and also the term CBHC. Do you differentiate between the two, and what is their relation to one another?

Werner: *Community-based* should mean *community-based,* but ever since WHO invented the term *community-based rehabilitation* for a top-down process imposed on communities more than coming from them, it has really kind of undermined the term. So many terminologies of solidarity have been

co-opted by the powers that be. In Mexico, the term *solidarity* itself has now been co-opted and corrupted.

I've come to use the term *community-controlled* rather than *community-based,* to distinguish from the misuse and overuse of the term *community-based.* We feel it's so important that the community of poor or disadvantaged people have control, because in many communities, in so-called community-based programmes, the local power structure still has a dominating role. The programme may be called community-based, but it was started in the community with the help of an NGO or another agency and many of the community's wealthier, stronger, and more dominant personalities have moved into the positions of leadership and now manipulate some of the decisions to the advantage of the privileged within the community. In thinking of community, we need to get back and look at the question of class structure.

Sköld: How would you see the relation between the community-controlled health programme and public health services? Where is the control?

Werner: It's very unusual, if it happens at all, that the community controls a government health service. I think that's a fiction. It's important in a community-controlled health care programme that the people don't fall into the trap of letting the government off the hook. Governments have also picked up on terms such as *community-based, self-sufficiency,* and *self-determination* and used them in making excuses for cutting back on health services. It's one thing for a community of disadvantaged people to come together and struggle for their health and their rights and to take the initiative. It's another thing for a government to impose self-financing on a poor community in the name of self-reliance. So it's very important for community-controlled health programmes to keep pressure on government and to be critical of cutbacks in health services and in food subsidies and in all of the other ways that are increasing poverty and hunger of the poor.

Sköld: You mentioned earlier that a health programme can be used as an entry point into the process of liberation. How is this process started? I would like to relate this to the role of NGOs, the role of agents that do not belong to the community but who would like to participate in the liberation process. Where does one start?

Werner: I think that the key is in a process of situational analysis done by the community itself. So often progressive NGOs move into areas where people are oppressed, very poor, with few rights and enormous health needs. By beginning to work on the health problems, the people begin to get a sense of their power to affect at least some aspects of their lives. In the process of situational analysis, determining the causes of poor health, people begin to move back from focusing on curative action to preventive action, and finally they begin to take socio-political action. If they're operating under a repressive regime, then often they become a target, as has happened in so much of Latin America and in the Philippines, for example. Then a lot of health workers go underground, and in the process of going underground they join the larger struggle for social change. Certainly this was the case in Nicaragua. The people needed to defend themselves against the abuses of repression that were affecting their health, and the health workers not only joined the resistance movement for change but helped to create it.

Another enormously important thing in the PHC movement, or community-controlled health care movement, is human rights. The powers that be are becoming more coercive, more oppressive, and in many countries we're seeing outrageous violations of human rights related to this. I think groups working for popular movements and community health need to be very firm on the question of human rights and to denounce abuses of human rights, even when it involves a risk. They need to establish links with the human rights commissions in their areas, as well as with Amnesty International and other international groups. □

USEFUL RESOURCE MATERIAL

Tools for Community Participation—A Manual for Training Trainers in Participatory Techniques by Lyra Srinivasan

Published as part of the PROWWESS/UNDP Technical Series Involving Women in Water and Sanitation, this manual is a detailed account of the SARAR approach to participatory training. The focus of PROWWESS is the role of women in the community as collectors and users of water and the promoters of family health. Yet the methods described in this book are applicable to almost any training situation where changes in attitudes and actions are as important as exchange of information. The author points out that the idea of the book is to tell the reader how it was done by one agency. It gives descriptions, not prescriptions. Many of the techniques and activities included are described in a "how to" step-by-step fashion, yet the reader is cautioned from the beginning against thinking of activities as a bag of tricks to enliven a training session. That would defeat the purpose of the participatory approach.

The book is fully illustrated with photographs, drawings, graphics, and field examples. There is an accompanying video, showing the process unfolding in an actual field workshop. The video and manual are available in English and French for US$35 (US$25 to agencies in developing countries). The manual alone in English may be obtained for US$15 (US$10 to agencies in developing countries). Available from PACT, Inc. at the following address:

PACT, Inc.
777 United Nations Plaza
New York, New York 10017
U.S.A.

Time to Listen—The human aspect in development by Laurence Taylor and Peter Jenkins

This book is composed almost entirely of one-page case studies, based on actual experience from all over the world. They make fascinating reading and are intended to promote reflection and awareness-raising among a variety of individuals and groups involved in development. Grouped into chapters, the case studies illustrate a number of subjects, for example, the unintended effects of development, pressure from donors, business and development, and politics and development. The authors provide a short introduction, and the case studies are punctuated with brief discussion questions. At the end of the book are suggestions for facilitating techniques.

The book is based on the premise that development that does not involve local people in decision-making will not necessarily produce the desired results, and much that is called development goes on in an insensitive way. The real problems of the poorest of the poor are not always understood, and yet there is surprise when programmes intended for their benefit do not actually help. The authors insist that it is time to listen. Before an answer is given, the question must be understood. Before an intervention is made, its full relevance must be considered. This book is intended to promote listening for the sake of understanding.

For information on how to obtain *Time to Listen* (ISBN 185339 004 6), please write directly to the publisher at the following address:

Intermediate Technology Publications
Intermediate Technology Development Group
103/105 Southampton Row
London WC1B 4HH
United Kingdom.

Implementing Primary Health Care—Experiences since Alma-Ata by Pieter Streefland and Jarl Chabot (eds.)

Many books have been written on PHC since Alma-Ata, and therefore the need for another volume on the subject may not be obvious. Indeed, the introduction to *Implementing Primary Health Care* is lacking in new or practical information. Nonetheless, the book is worth reading for its useful discussion of some of the key issues in PHC: equity; community participation; community health workers; village health committees; financing of PHC;

appropriate technology; and the balancing of curative with preventive activities and selective with comprehensive approaches, for example.

The book also presents case studies and descriptions of actual PHC programmes in Asia, Africa, and Latin America. These presentations are realistic and compelling. They provide interesting examples of how to initiate and manage comprehensive PHC programmes in various settings, the achievements that are possible, but also the problems and limitations that are encountered.

The publication is based on the proceedings of a workshop that brought together technical advisers and practitioners with many years experience in the field but who are usually too busy to write or publish. The resulting material is useful to health workers who would like to initiate PHC activities or who are faced with problems in PHC implementation.

Available at Dfl 39.50 in English (ISBN 90 6832 034 3) and French (ISBN 90 6832 035 1) from KIT Press, the publications department of the Royal Tropical Institute (KIT), Amsterdam, The Netherlands, at the following address:

KIT Press
Royal Tropical Institute
Mauritskade 63
1092 AD Amsterdam
The Netherlands.

Child-to-Child Primary Health Readers by the Voluntary Health Association of India (VHAI)

How do we teach and encourage primary school children to become aware of their health and development problems or to become involved in the health of their younger brothers and sisters?

The Voluntary Health Association of India (VHAI) has produced a series of readers that have been developed for this purpose for children in India. The series of five booklets, delightfully and colourfully illustrated and clearly presented will tempt any child to read them and discover, for example, how Saroja takes good care of her brother and mother when they are ill and there is no doctor around; how families can help one another to prevent accidents; how we can take care of our teeth; how the little town of Kachrapur became healthier and cleaner; and, finally, how Shanti and her friend arrange a stall of health food for the annual school fair.

For information on how to obtain these readers, please contact VHAI directly at the following address:

Voluntary Health Association of India
Tong Swasthya Bhavan
40 Institutional Area
Near Centab Hotel
New Delhi—110 016
India.

CONTACT is the periodical bulletin of the Christian Medical Commission (CMC) of the World Council of Churches (WCC). It is published six times a year in English, French, Spanish and Portuguese. Selected issues are also published in Kiswahili in Kenya, and Arabic in Cyprus. Present circulation exceeds 35,000.

CONTACT deals with varied aspects of the community's involvement in health and seeks to report topical, innovative, and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the first annual issue of each language version. Articles may be freely reproduced, providing that acknowledgement is made to CONTACT, the bi-monthly bulletin of the Christian Medical Commission of the World Council of Churches.

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